

# Suncorp Employee Superannuation Plan

## Insurance application form



Suncorp Portfolio Services Limited (Trustee)  
 ABN 61 063 427 958 AFSL 237905 RSE L0002059

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**Please use this form to apply for insurance cover if you're a member of the Suncorp Employee Superannuation Plan and:**

- Are making a new application for cover or
- Are applying for an increase to your existing cover (additional cover)

**Please note:**

- If you're a non-employed member with existing insurance cover, you can apply for an increase to your current Death only or Death & Total and Permanent Disability cover only – please choose 'Additional Cover' and specify the amount you would like to increase your existing insurance cover by
- If you're a non-employed member without existing insurance cover, insurance is not available within your super account
- If you're a family account member, you can apply for Death only or Death & Total and Permanent Disability (TPD) cover in addition to your account balance – please choose 'Additional Cover' when selecting your insurance amount

**Tips to help you complete this form**

- Use blue or black pen and CAPITAL letters
- Use a cross (X) to mark answer boxes
- Complete all sections of the form and sign and date on the last page

**Any questions?** If you'd like help completing this form, or if you have any questions, please call us on 1800 652 489 between 8am and 6pm (Eastern Standard Time) Monday to Friday.

### Your duty of disclosure

**To be read by the Insured Person before completing the application.**

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

Your duty, however, doesn't require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that's of common knowledge
- that the insurer knows, or in the ordinary course of their business, ought to know
- as to which compliance with your duty is waived by the insurer.

**Non-disclosure** – If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it.

If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

The insurer may elect not to avoid your contract but to vary it by:

- (i) reducing the sum insured in accordance with a formula that takes into account the premium that would have been payable if you had complied with your duty of disclosure; or
- (ii) placing the insurer in the position in which the insurer would have been in if you had complied with your duty of disclosure.

The options to vary the contract are available to the insurer while the contract remains in force.

Where your contract provides death cover, the insurer may only apply (i) above and must do so within 3 years of you entering into the contract with them.

Your duty of disclosure continues to apply until the contract is entered into. It also applies when you extend, vary or reinstate a contract of life insurance.

### 1. Personal details

Suncorp Employee Superannuation Plan account number

Title  Single  Married  De-facto  Gender: Male  Female

Last name

Given name(s)

Date of birth   /   /

Daytime phone number           Mobile

Email



**How to complete the rest of this application**

You can complete 'Part A – Short personal health statement' if the following applies to you	You must complete 'Part B – Full personal health statement' if the following applies to you
You're under age 55 and applying for sums insured up to the AAL (including any existing cover) for Death only or Death and TPD. You can't complete 'Part A – Short personal health statement' if you're applying for IP. Please complete 'Part B – Full personal health statement'. <b>Please note if you answer "Yes" to any of the questions in 'Part A – Short personal health statement', you'll also need to complete 'Part B – Full personal health statement'.</b>	You're age 55 and over or <ul style="list-style-type: none"> <li>• would like sums insured over the AAL (including any existing cover), for Death only or Death and TPD and/or</li> <li>• you're applying for Income protection (IP)</li> </ul>

**PART A – Short personal health statement**

Only complete Part A where you are under age 55 and applying for sums insured up to the AAL (including any existing cover) for Death only or Death and TPD. If this does not apply to you or you are also applying for Income Protection you must complete Part B.

Please provide the following details:

Height \_\_\_\_\_ cm or \_\_\_\_\_ feet/inches

Weight \_\_\_\_\_ kg or \_\_\_\_\_ stone/pounds

Have you smoked tobacco or any other substance in the last 12 months? .....  Yes  No

**Important information**

**If you answer "Yes" to any of the questions in the short personal health statement below, please DO NOT continue completing this section. Instead, please complete Part B.**

1. Do you engage in any hazardous activities, pursuits or occupational duties, such as but not limited to motorised sports, scuba diving below 40 metres or aviation (other than as a fare paying passenger on a licensed public service (eg Qantas))? .....  Yes  No
2. Do you have any definite plans to travel or reside overseas in the future? (Holidays less than 4 weeks don't need to be disclosed) .....  Yes  No
3. Have you ever suffered symptoms of, or had, or been told you have, or received or are contemplating any advice or treatment for:
  - i) Muscular skeletal disorders (eg back, joint), arthritis, loss of limb or paralysis .....  Yes  No
  - ii) Impairment of sight or hearing (not including long or short sightedness) .....  Yes  No
  - iii) Mental or nervous disorder including stress, anxiety, depression or neurological condition .....  Yes  No
  - iv) Cancer or tumour of any type .....  Yes  No
  - v) Diabetes or liver disease including hepatitis .....  Yes  No
  - vi) High blood pressure, high cholesterol, chest pain, heart complaint or stroke .....  Yes  No
  - vii) Disorders and or disease of the kidney, bladder, bowel or stomach? .....  Yes  No
4. Have you ever:
  - i) Suffered from AIDS or been infected with the HIV virus, or .....  Yes  No
  - ii) Used intravenous drugs or had sexual activity with someone you know or suspect to be HIV positive, or .....  Yes  No
  - iii) Engaged in male to male anal sexual activity? .....  Yes  No
5. To the best of your knowledge, have two or more members of your immediate family, i.e. parents, brothers or sisters (living or deceased) suffered from any hereditary disease before age 60? .....  Yes  No
6. Does your alcohol consumption exceed more than 20 standard drinks per week? .....  Yes  No

**If you answered "No" to all of the above questions, please go straight to Section 13 'Declaration and signature'.**

## PART B – Full personal health statement

### 5. Residence and travel (must be completed)

1. Were you born in Australia? .....Yes  No   
 If 'yes', please go straight to question 3
2. Are you an Australian citizen or do you hold an Australian Permanent resident visa? .....Yes  No
- How long have you lived in Australia?  Country of birth  Visa type
3. Do you travel overseas in your job? .....Yes  No
- Countries  Purpose   
 Duration  Frequency
4. Do you have definite plans to live or travel overseas in the future? .....Yes  No
- If 'yes', please advise Date leaving  /  /  /  /  /  Date returning  /  /  /  /  /
- Countries to be visited  Reason for trip

### 6. Medical history (must be completed, except when a medical examination is required)

1. What is your height and weight?  
 Height  cm or  feet/inches  
 Weight  kg or  stone/pounds
2. Are you left handed or right handed? Left  Right
3. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- a. Heart attack, angina, chest pain, stroke, hypertension (high blood pressure) or high cholesterol readings? .....Yes  No
- b. Asthma, bronchitis, emphysema? .....Yes  No
- c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder? .....Yes  No
- d. Epilepsy, fainting attacks or fits of any kind? .....Yes  No
- e. Recurrent indigestion, ulcer, Hepatitis (A, B, C or D)? .....Yes  No
- f. Cancer, tumour, sunspot, skin cancer, lump or growth of any kind or breast lumps (even if you have not seen a doctor)? .....Yes  No
- g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses) .....Yes  No
- h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs? .....Yes  No
- i. Arthritis, gout, fibromyalgia, osteoporosis, tendonitis, tenosynovitis, overuse syndrome or any regional pain syndrome or chronic fatigue? ....Yes  No
- j. Diabetes or abnormal blood sugar? .....Yes  No
- k. Psoriasis, eczema or any other disorder of the skin, or any allergic or chemical sensitivity reaction? .....Yes  No
- If you answered 'yes' to any of the conditions above, please also complete a Special health questionnaire (on pages 9 to 12) for each condition.**
4. Other than those conditions stated in question 3, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- a. Heart murmur or any other heart or blood vessel disorder? .....Yes  No
- b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? .....Yes  No
- c. Tuberculosis or any other lung or respiratory system disorder? .....Yes  No
- d. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? .....Yes  No
- e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancrea? ....Yes  No
- f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? ..... Yes  No
- g. Sleep apnoea or any sleeping disorder? .....Yes  No
- h. Thyroid disorder or any other glandular disorder? .....Yes  No
- i. Any sickness, injury or physical impairment not previously mentioned? .....Yes  No
5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)? .....Yes  No
6. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result? .....Yes  No
7. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation? .....Yes  No
8. Other than already stated, during the last 3 years have you been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist or any other health care professional, been in hospital, had any operation or had any tests or investigations (eg, x-ray, ECG etc)? .....Yes  No



Question no.  Sickness, injury or tests

Test results

Date commenced  Time off work  Degree of recovery (%)

Date of last symptoms  Treatment received

Full name and address of doctor or hospital

State Postcode

Question no.  Sickness, injury or tests

Test results

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Question no.  Sickness, injury or tests

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Date of last symptoms  Treatment received

Full name and address of doctor or hospital

State Postcode

Question no.  Sickness, injury or tests

Test results

Date commenced  Time off work  Degree of recovery (%)

Date of last symptoms  Treatment received

Full name and address of doctor or hospital

State Postcode

**7. Habits** (must be completed, except when a medical examination is required)

1. Have you ever smoked tobacco or any other substance, or, in the last 12 months, used any nicotine replacement therapy product? .....Yes  No

If 'yes', type (eg, cigarettes, gum, patches)?  ..... Daily quantity?

How many years?  Date ceased? if applicable

Other

2. Do you drink alcohol? .....Yes  No

If 'yes', please advise number of standard drinks per week?  Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? .....Yes  No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol?.....Yes  No

If you answered 'yes' to question 3 or 4, please provide details in the following table

Question no.	Date from	Date to	Type of usage (alcohol, heroin etc)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		

**8. Doctor's details** (must be completed)

If you don't have a usual doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your usual doctor

Address  Postcode

Work phone (  ) Fax (  )

2. How long have you been a patient of this doctor?  Date of last consultation | d | d | / | m | m | / | y | y | y | y |

Reason and outcome of last consultation

3. If you've been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address  Postcode

Please provide date, reason and outcome of last consultation(s).

**9. HIV** (must be completed)

1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV? .....	<b>Yes</b>	<b>No</b>
	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 3 years have you or do you intend to:	<b>Yes</b>	<b>No</b>
a. Work as or engage in sexual intercourse with a prostitute? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Engage in male to male anal sexual activity? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Have sexual intercourse with an intravenous drug user? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Have sexual intercourse with someone you suspect or know to be HIV positive? .....	<input type="checkbox"/>	<input type="checkbox"/>

**If you have answered 'yes' to any of the above, our underwriters will contact you for further information.**

**10. Activities** (must be completed)

1. In the last 12 months have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity eg, football, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (eg, Qantas)? .....Yes  No

If 'yes', please answer the activities questionnaire on page 8.

2. Type of activity?

3. Do you want to be considered for cover whilst taking part in this activity?.....  Yes, please complete Section 11  No

**11. Activities questionnaire** (must be completed if you indicated 'yes' in Section 10 question 3)

**Underwater diving**

a. Type (scuba, hookah etc)  b. What are your qualifications for this activity?

c. How long have you been doing this?  d. How often do you do this?

e. Are you professional or amateur?

f. Maximum depth of dives  Metres g. Average depth of dives  Metres

h. Geographical location

i. Do you dive in wrecks, potholes or caves? ..... Yes  No

j. Have you ever had a diving accident or diving sickness? (eg, blackout, needed decompression etc) ..... Yes  No

k. Do you intend to change the scope of your license/participation? ..... Yes  No

If 'yes' to i – k, please provide details.

**Motor sports**

a. Type (car, bike etc)  b. Events (speedway, off road etc)

c. How long have you been doing this?  d. How often do you do this?

e. Are you professional or amateur?

f.

Category (eg, touring cars)	Class (eg, A/A/D)	Vehicle & type of fuel	Engine capacity	No. of vehicles in event	Max speed km/hour
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

k. Do you intend to change the scope of your license/participation? ..... Yes  No

If 'yes', please provide details.

**Flying – power-driven aircraft or conventional glider**

a. What type of flying do you do (private, agricultural, ultralight etc)?

b. Total number of hours flown as a pilot?  Hrs Number of hours in the past 12 months? Fixed Wing  Hrs Helicopter  Hrs

c. Number of hours expected in the next year? Fixed Wing  Hrs Helicopter  Hrs

d. Geographical location

e. What class license do you hold?

f. Do you intend to change the scope of your license? ..... Yes  No

If 'yes', please provide details.

**Abseiling, caving, mountaineering, rock climbing**

a. Activity

b. How long have you been doing this?  c. How often do you do this?

d. Geographical location

e. Maximum altitude/depth  f. Equipment used

g. Maximum grade of climb  h. Type (top roping etc)

**Other activity**

a. Describe activity  b. What are your qualifications for this?

c. How long have you been doing this?  d. How often do you do this?

e. Geographical location  f. Are you professional or amateur?



## 12. Special health questionnaires

### Skin Lesion/Skin Cancer/Sun Spot

1. How many skin lesions, skin cancers or sun spots have you had treated? .....
2. Please provide details of each of the above in the table below. If more than 3, provide details on a separate page.

	Lesion 1	Lesion 2	Lesion 3
a) Where on the body was it located: eg, arm, nose, scalp.			
b) Was the lesion benign or malignant?			
c) What was the diagnosis? ie the name advised by your doctor eg, melanoma, BCC, keratosis etc.			
d) What was the date of diagnosis, biopsy, or treatment?			
e) How was it treated?* See examples of treatment types below.			

**\*Examples of treatment types:** Excised (surgically removed), curettage (removal with a scraping instrument), cryotherapy (freezing off), diathermy (burning off), topical cream eg, Efudix/Aldara or photodynamic therapy.

3. Have you been advised to have regular skin checks? ..... Yes  No   
If 'yes', please advise by whom and the frequency.

4. What was the date and result of your last skin check and the name and address of the doctor or clinic consulted?  
Name and address

Date / /

5. Has any further follow-up or treatment been recommended? ..... Yes  No   
If 'yes', please provide details.

6. Do you have or can you obtain a copy of any pathology reports which relate to the skin lesion(s)/cancer(s) or sun spot(s) treated? ..... Yes  No   
If 'yes', please attach a copy to this application.

7. Does your regular doctor, skin specialist or skin clinic have details regarding the lesion(s)/cancer(s) or sun spot(s)? ..... Yes  No   
If 'yes', please indicate which one and provide the name and address if it's not your usual doctor.

If 'no', please provide the name and address of the doctor who has full details.

Name and address

  


8. Do you have any skin lesions for which you are considering consulting a doctor or seeking medical advice or treatment? ..... Yes  No   
If 'yes', please provide details.

## Hypertension (High Blood Pressure)

1. When were you first diagnosed with hypertension? [d][d]/[m][m]/[y][y][y][y]

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition? ..... Yes  No

If 'yes', please advise commencement date, type, dosage and frequency.


4. Please provide details of your last two readings/tests, including dates and any change to your treatment

Date	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
/ /		
/ /		

5. Have you had an electrocardiogram (ECG), Blood Pressure monitor or any other heart test? ..... Yes  No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.


6. Do you have any complications as a result of hypertension? ..... Yes  No

If 'yes', please provide details


7. Does your regular doctor have details of this condition? ..... Yes  No

If 'no', please provide the name and address of the doctor who has full details


## High Cholesterol

1. When were you first diagnosed with high cholesterol/triglycerides? [d][d]/[m][m]/[y][y][y][y]

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition? ..... Yes  No

If 'yes', please advise commencement date, type, dosage and frequency.


4. Please provide details of your last two cholesterol test results, including dates and any change to your treatment

Date	Result (If unsure, answer 'unsure')	If treatment was changed, give details
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	

5. Have you had an electrocardiogram (ECG), blood pressure monitor or any other heart test? ..... Yes  No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.


6. Does your regular doctor have details of this condition? ..... Yes  No

If 'no', please provide the name and address of the doctor who has full details


## Asthma

1. Date asthma first diagnosed  /  /
2. How often do you experience symptoms? eg, wheezing, breathlessness, chest tightness.
3. When did you last experience symptoms?  
 /  /
4. Are you woken during the night with symptoms?..... Yes  No   
If 'yes', how often and date of last occurrence.
5. Have you ever been off work due to your asthma? ..... Yes  No   
If 'yes', please advise when and for how long.
6. What is your current treatment? Include type of medication and dosage.
7. Have you ever required use of oral steroids? ..... Yes  No   
If 'yes', please advise when and for how long.
8. Have you ever been in hospital or received emergency treatment for asthma? ..... Yes  No   
If 'yes', please advise when, for how long and where.
9. Do you ever measure your peak flow? ..... Yes  No   
If 'yes', please advise your highest and lowest readings in the past 6 months.
10. Have you ever consulted a specialist for this condition? .... Yes  No   
If 'yes', please advise name and address of doctor and date of last consultation.
11. Does your regular doctor have details of this condition?..... Yes  No   
If 'no', please provide name and address of doctor who has full details.
12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

## Anxiety/Depression/Nervous disorder

1. Nature of condition and underlying cause.
2. Describe your symptoms.
3. Date symptoms commenced.  /  / 
  - i) Are you still experiencing symptoms? ..... Yes  No
  - ii) If 'no', when did you last experience symptoms?  
 /  /
4. Have you had any recurrence of this condition? ..... Yes  No   
If 'yes', please advise when and how many times.
5. Have you taken regular or occasional medication for this condition? ..... Yes  No   
If 'yes', please advise type, dosage and frequency.
6. Are you still taking this medication? ..... Yes  No   
If 'no', please advise date ceased  /  /
7. Have you had any other treatment (eg, counselling, hospitalisation, ECT)?..... Yes  No   
If 'yes', please advise type, dates, hospital and name and address of treating doctor.
8. Have you ever been off work or had your normal daily activities restricted in any way due to this condition?..... Yes  No   
If 'yes', please advise when and for how long.
9. Have you any ongoing effects or restriction in your activities of any kind?..... Yes  No   
If 'yes', please provide details.
10. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? ..... Yes  No   
If 'yes', please advise dates and name and address of all persons consulted.
11. Please provide details of your most recent visit for this condition. Include date, name and address of the doctor or health professional consulted.
12. Does your regular doctor have details of this condition?..... Yes  No   
If 'no', please provide name and address of doctor who has full details.

**Back/Neck**

- Area of spine affected? Neck, upper or lower back?
- Date of first symptoms
- What was the cause?
- Have you had any diagnostic investigations eg, CT Scans, x-rays etc? ..... Yes  No   
 If 'yes', please provide details of test(s), result(s) and date(s).
- Are you still experiencing symptoms? ..... Yes  No   
 If 'no', please provide date of last experienced symptoms?
- How often do/did you have symptoms?
- Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ..... Yes  No
- Have you ever been off work due to your spinal symptoms or unable to perform your normal day to day activities? ..... Yes  No   
 If 'yes', when and for how long?
- What is the nature of the treatment (eg, spinal manipulation, deep tissue massage etc)?  
  
 i) Are you still receiving treatment? ..... Yes  No   
 ii) If 'no', when did you cease treatment?
- Have you ever consulted a specialist for this condition? ..... Yes  No   
 If 'yes', provide name and address of specialist and date of last consultation.
- Please provide details of your most recent visit to any other doctor or therapist for this condition. Include date, name and address of doctor or therapist consulted.
- Have you had any ongoing effects of any kind? Eg, pain, discomfort or limitations of movement etc? ..... Yes  No   
 If 'yes', please provide details.
- Is it necessary to avoid lifting or to restrict your daily activities in any way? ..... Yes  No   
 If 'yes', please provide details.
- Does your regular doctor have details of this condition? ..... Yes  No   
 If 'no', please provide name and address of doctor who has full details.

**Any other condition**

- Name of condition (exact diagnosis)
- The cause
- a. Describe symptoms   
 b. Date symptoms commenced   
 Date symptoms ceased   
 c. How often do/did you have symptoms?
- Have you ever been off work or had your normal daily activities restricted in any way because of this condition? ..... Yes  No   

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		
- Have you any residual, on-going effects or restriction in your daily activities? ..... Yes  No   
 If 'yes', please provide details.
- Have you taken regular or occasional medication for this condition? ..... Yes  No   
 If 'yes', please advise names of medication(s), dosage(s) and frequency.  
  
 Are you still taking this medication? ..... Yes  No
- Have you had any other treatment for this condition (eg, physiotherapy, operation, alternative remedies)? ..... Yes  No
- Have you had any diagnostic investigations (eg, scope, scan, x-rays, EEG, ECG etc)? ..... Yes  No
- Have you ever been in hospital or received emergency treatment for anything related to this condition? ..... Yes  No
- If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.
- Details of your most recent visit to a doctor or other therapist for anything related to this condition.  

Date	Reason for consultation, investigations, findings, advice
/ /	

 Doctor/Therapist name and specialty
- Has further treatment been recommended for this condition? Yes  No   
 If 'yes', please provide details.
- Does your regular doctor have details of this condition? ..... Yes  No   
 If 'no', please provide name and address of doctor who has full details.

